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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11755

CERTIFICATE OF DEATH

11755

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Preston</u>		<u>Life</u>		TOWN <u>Preston, MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First)		(Middle)		(Last)			
<u>Ulyses</u>		<u>G.</u>		<u>Adams</u>			
5. SEX		6. COLOR OR RACE		8. DATE OF BIRTH		9. AGE last birthday	
<u>male</u>		<u>Col</u>		<u>8/14/77</u>		<u>78</u> yrs.	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		<u>married</u>		10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
<u>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</u>		<u>Farm owner</u>		<u>11. BIRTHPLACE (State or foreign country)</u>		<u>U.S.A.</u>	
<u>Farmes</u>		<u>13. FATHER'S NAME</u>		<u>14. MOTHER'S MAIDEN NAME</u>			
<u>Edward Adams</u>		<u>Harriett Camper</u>		<u>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</u>		<u>16. SOCIAL SECURITY NO.</u>	
<u>17. INFORMANT & ADDRESS</u>		<u>Mrs Mary Adams</u>		<u>Preston MD</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.0 IMMEDIATE CAUSE (A) <u>Chronic Congestive Heart Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis Generalized</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Chronic Glomerular Nephritis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>July 10</u> , 19 <u>40</u> , to <u>12/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>55</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James B. Plummer, M.D.</u>				ADDRESS <u>Preston, Maryland</u>		DATE SIGNED <u>12/16/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/16/55</u>		<u>Mt. Pleasant cem</u>		<u>Preston, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25a. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12-16-55</u>		<u>Cornelia W. Plummer</u>		<u>James B. Plummer</u>		<u>Easton, Md.</u>	

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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BUREAU V. S.

DEC 20 1955

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11756

CERTIFICATE OF DEATH

11756

Reg. Dist. No. 64

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Federalsburg</u>		<u>31 years</u>		TOWN <u>Federalsburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>109 West Central Avenue</u>				STREET ADDRESS (If rural give location) <u>109 West Central Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Margaret</u> (Middle) <u>Stayton</u> (Last) <u>Anderson</u>				(Month) <u>December</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>January 4, 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Greenwood, Delaware</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Nehemiah Stayton</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Jacob O. Williams, Federalsburg, Md.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						19. INTERVAL BETWEEN ONSET AND DEATH	
199.1 IMMEDIATE CAUSE (A) <u>Broncho-pneumonia</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cachexia</u>						<u>5 mon.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Squamous cell carcinoma, lt. ear</u>						<u>7 mon.</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive cardiovascular disease.</u>						<u>1-2 yr.</u>	
19a. DATE OF OPERATION <u>May 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Squamous cell carcinoma, lt. ear</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-2-</u> , <u>1955</u> , to <u>12-13</u> , <u>1955</u> , that I last saw the deceased alive on <u>12-13</u> , <u>1955</u> , and that death occurred at <u>12:15A</u> , from the causes and on the date stated above.							
SIGNATURE <u>R. C. Kingsbury</u>				ADDRESS (Street, city, town, state) <u>Federalsburg, Maryland</u>			
DATE <u>Dec. 16, 1955</u>				DATE SIGNED <u>Dec. 15, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 16, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

Form 100-1-54

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO COUNTY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO LOT

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO COFFIN

DATE OF ENTRY INTO GRAVE

BUREAU V. S.

DEC 28 1955

RECEIVED

INSTRUCTIONS: This form is to be filled out by the physician or other person having knowledge of the cause of death. It is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland. The form is to be filled out in duplicate. One copy is to be filed in the office of the Registrar and the other copy is to be filed in the office of the physician or other person having knowledge of the cause of death. The form is to be filled out in duplicate. One copy is to be filed in the office of the Registrar and the other copy is to be filed in the office of the physician or other person having knowledge of the cause of death.

11757

11757

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Federalburg</u>		LENGTH OF STAY (in this place) <u>10 years</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Federalburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>River Road</u>				STREET ADDRESS (If rural, give location) <u>River Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Charles Wesley Dickerson</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>December 7 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Feb. 21, 1878</u>	9. AGE last birthday: <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Federalburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Henry Dickerson</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Maria Thomason</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>183-20-8497</u>		17. INFORMANT & ADDRESS: <u>Louise Bolden, Wilmington, Delaware</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Cardiovascular Disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>8</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Laneon D. George</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/8/55</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalburg, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>December 5, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.J. Frampton and Son, Federalburg, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 28 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11758

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12577 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
X TOWN <u>Federalsburg - Rural</u>		<u>3 months</u>		TOWN <u>Federalsburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Allen's Corner</u>				STREET ADDRESS (If rural, give location) <u>Near Allen's Corner</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Clarence</u>		(Middle) <u>Duley</u>		(Last)	
4. DATE OF DEATH		(Month) <u>December</u>		(Day) <u>25</u>		(Year) <u>19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>C olored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>December 30, 1913</u>	9. AGE last birthday: <u>41</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Day Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Logging</u>		11. BIRTHPLACE (State or foreign country): <u>Rocky Mount, N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Mary B. Duley, Federalsburg, Maryland</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
981X Immediate cause (a) <u>Hemorrhage - Shock</u> DUE TO Antecedent cause(s) (b) <u>Gun Shot Wound, 17 Chest</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							<u>few minutes</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) <u>Federalsburg</u> (County) <u>Caroline</u> (State) <u>Ind</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-25-55 9:30 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Gun Shot Wound -</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Winson S. George</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>12/26/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 3, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 3, 1956</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

BUREAU V. S.

JAN 8 1958

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

11759

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

12578

Reg. Dist. No. 63

1. PLACE OF DEATH COUNTY <u>Caroline</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston R.D.</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Preston R.D.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1210</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>Effie</u> (First) <u>Sayer</u> (Middle) <u>Engle</u> (Last)		4. DATE OF DEATH <u>Dec.</u> <u>12</u> <u>1955</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>N.W.</u>		8. DATE OF BIRTH <u>12/5/1881</u>		9. AGE last birthday <u>74</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Calvin Seerist</u>			
14. MOTHER'S MAIDEN NAME <u>Hannah Wiese</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY No. <u>No</u>				17. INFORMANT <u>Rene Engle - Preston Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>420.1</u> <u>Myocardial Infarction</u>						<u>3 weeks</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Arteriosclerotic Coronary Disease</u>						<u>1 yr</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/1/1954</u> , to <u>12/12/1955</u> , that I last saw the deceased alive on <u>12/10/1955</u> , and that death occurred at <u>—</u> m., from the causes and on the date stated above.							
SIGNATURE <u>M. E. Easton</u>				ADDRESS <u>Preston Md</u>			
DATE SIGNED <u>12/13/55</u>							
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>12/14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Linchester</u>		LOCATION (City, town, or county) (State) <u>Preston Md R.D.</u>	
DATE REC'D BY LOCAL REG. <u>12/13/55</u>		REGISTRAR'S SIGNATURE <u>A. H. Neeris</u>		24. FUNERAL DIRECTOR <u>M. E. Neuman + Son - Eastern Md</u>		ADDRESS <u>—</u>	

Cornelia D. Plummer

Two For One Certificate Film #191 - 1/20/56
Mnt.

BUREAU V. S.

JAN 17 1956

RECEIVED

11760

CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Greensboro</u>		<u>33 Yrs.</u>		TOWN <u>Rural Greensboro</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>L. Anna Harper</u>				<u>12 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>3/4/1899</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Hignutt</u>				<u>Rachel Nicholes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>Wm. G. Harper Greensboro, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Crownary Thromboses</u>							
ANTECEDENT CAUSE (S) DUE TO <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>0</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 10</u> , 19 <u>55</u> to <u>Dec. 19</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Dec. 19</u> , 19 <u>55</u> , and that death occurred at <u>8A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Stouffer</u>		M.D. <u>Greensboro, Caroline</u>		DATE SIGNED <u>12/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/22/55</u>		<u>Greensboro</u>		<u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>12/22/55</u>		<u>L. MacLennan</u>		<u>J. E. Boulaix</u>		<u>Greensboro, Md.</u>	

MARGIN RESERVE FOR BINDING

THE APTITUDE



5. The following are the names of the persons who have been appointed to the various positions in the organization:

11761 CERTIFICATE OF DEATH

Reg. Dist. No. 61

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>		LENGTH OF STAY (in this place) <u>25 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Greensboro</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Henson Melvin</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>12 16 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>7/14/1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James A. Melvin</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-12-5641</u>		17. INFORMANT & ADDRESS: <u>Bertha Melvin Greensboro, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE (S) <u>Arteriosclerotic Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>Diabetes Mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>6</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 14, 1955</u> , to <u>Dec. 16, 1955</u> , that I last saw the deceased alive on <u>Dec. 16, 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Stancifer</u>		M. D.		ADDRESS <u>Greensboro, Bertha Co. Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>		LOCATION (City, town, or county) (State) <u>Wilmington, Del.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12/19/55</u>		REGISTRAR'S SIGNATURE <u>L. M. Pappin</u>		24. FUNERAL DIRECTOR <u>J. E. Bouhais</u>		ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

214-15 2641

U.S.

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INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11762

CERTIFICATE OF DEATH

11760

Reg. Dist. No. 62

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Denton</u>		<u>Life</u>		TOWN <u>Denton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SAMUEL</u> (Middle) <u>GRAHAM</u> (Last) <u>NATTLE</u>				(Month) <u>DEC.</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>July 15, 1868</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Young</u>		<u>Farm owner</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Tilghman Noble</u>				14. MOTHER'S MAIDEN NAME <u>Emmaline Taylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				<u>Eura Martin Voss, Denton, Ind.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
196X IMMEDIATE CAUSE (A) <u>Causes of Louie Mandable</u>						<u>6 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Metastasis to Left Chest</u>						<u>2 "</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 14, 1954</u> to <u>Dec. 7, 1955</u> , that I last saw the deceased alive on <u>Dec. 7, 1955</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Amos D. George</u>				ADDRESS (Street, city, town, state) <u>Denton Ind.</u>			
DATE <u>12/8/55</u>				DATE SIGNED <u>12/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Dec 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>		LOCATION (City, town, or county) (State) <u>Denton, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Amos D. George</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. V. Voss</u>		ADDRESS <u>Denton, Ind.</u>	

UREAU V. S.

DEC 12 1955

RECEIVED

11763

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Goldsboro</u>		47 Yrs.		TOWN <u>Goldsboro</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
None				None			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Day) (Year)	
Agnes		Virginia		Seward		12 22 55 19	
(Type or Print)							
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED.		8. DATE OF BIRTH:	
Female		White		Single		4/16/1908	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		None		10B. KIND OF BUSINESS OR INDUSTRY:		None	
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Maryland				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Norman Seward				Maggie Sculley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO			
No				None			
17. INFORMANT & ADDRESS:							
Norman Seward Goldsboro, Md.							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Extremities</u>							
ANTECEDENT CAUSE (B) <u>Central Nervous System</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST						90 Days	
(C) <u>Intestinal Nephritis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?							
YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 weeks</u> , 19 <u>55</u> to <u>12/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/22</u> , 19 <u>55</u> , and that death occurred at <u>4:55</u> A.M. from the causes and on the date stated above.							
SIGNATURE		M. D.		DATE SIGNED			
<u>H. F. Seward</u>		<u>Goldsboro</u>		<u>12/23-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		12/24/55		Greensboro		Greensboro, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
12/24/55		<u>H. F. Seward</u>		<u>J. E. Bouleau</u>		<u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

STANDARD A S

1140

RECEIVED
JAN 11 1941

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

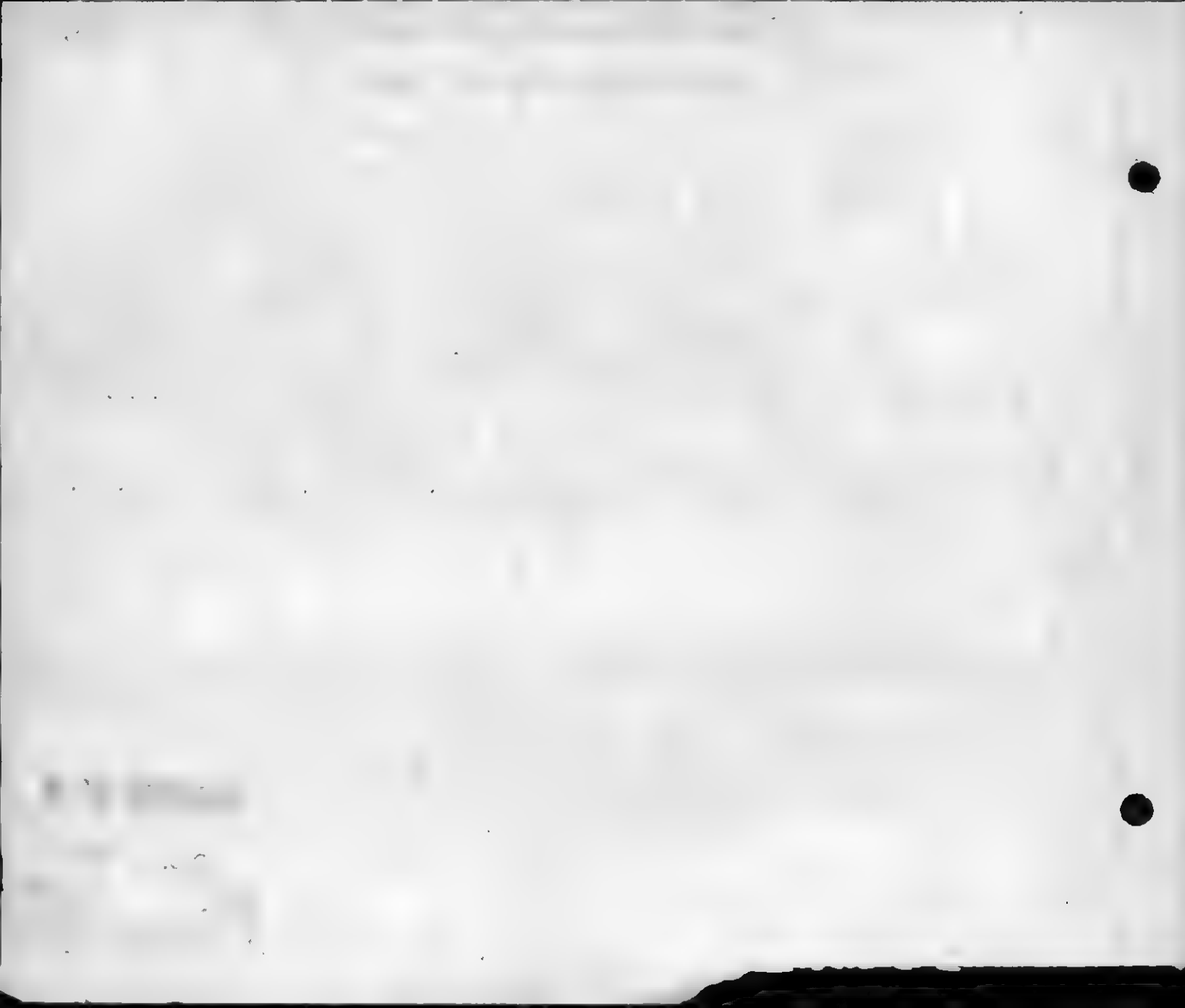
11762

11764

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Preston - Rural</u>		<u>10 years</u>		TOWN <u>Preston - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smithson</u>				STREET ADDRESS (If rural give location) <u>Smithson</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>Charles</u> (Middle) <u>George</u> (Last) <u>Truitt</u>				<u>December</u> <u>6</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>October 11, 1880</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>		<u>Farm Owner</u>		<u>Sussex County, Delaware</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Truitt</u>				<u>Julia Burton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>None</u>		<u>Mrs. Charles L. Perry, Preston, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						16. MEDICAL CERTIFICATION	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>6 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>U</u>							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		<u>M.</u>					
22. I hereby certify that I attended the deceased from <u>1/2</u> <u>19 51</u>, to <u>12/10</u> <u>19 55</u>, that I last saw the deceased alive on <u>12/16</u> <u>19 55</u>, and that death occurred at <u>11:30 AM</u>, from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Stacy B. Perryman</u>		<u>Preston, Maryland</u>		<u>Dec. 7, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 9, 1955</u>		<u>Bridgeville Cemetery</u>		<u>Bridgeville, Delaware</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12-7-55</u>		<u>Stacy B. Perryman</u>		<u>J.J. Frampton and Son, Federalsburg, Md.</u>			



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11765

Item 211-111m 6191 1-9-55 and

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11763

Reg. Dist.

No. 64

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR	
TOWN <u>Federalsburg</u>		<u>Life</u>		TOWN <u>Federalsburg</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Denton Road</u>				STREET ADDRESS (If rural, give location) <u>Denton Road</u>			
3. NAME OF DECEASED: (First) <u>James</u>		(Middle) <u>Carlton</u>		(Last) <u>Walls</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 20 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>Dec. 6, 1898</u>	9. AGE last birthday: <u>57</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>House Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Painting</u>		11. BIRTHPLACE (State or foreign country): <u>Caroline County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>J. Gardner Walls</u>				14. MOTHER'S MAIDEN NAME: <u>Sallie Polite</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>William P. Walls, Salisbury, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
916.0 Immediate cause (a) <u>Asphyxiation</u> DUE TO Antecedent cause(s) (b) <u>3rd Degree Burn entire body</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>Immediate</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>0</u>		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>05</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-20-55 12 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? (not a collision) <u>Burned in auto mobile</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Dr. J. George</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Dec. 21, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Dec. 20, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS	

BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR <input checked="" type="checkbox"/> TOWN <u>Preston</u>		LENGTH OF STAY (in this place) <u>40 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Preston</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>60</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>H</u> (Middle) <u>Zacker</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>7</u> (Year) <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/9/1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Zacker</u>				14. MOTHER'S MAIDEN NAME <u>Selma Kleinwachter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>William Kleinwachter</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u>						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u> </u>		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Home</u> <u>12/10/55</u> death, 19<u>55</u>, that I last saw the deceased alive on <u>12/10/55</u>, and that death occurred at <u>4:45</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Lawson O. George</u>		DATE THEREOF <u>12/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Jr. O.U.A.M.</u>		LOCATION (City, town, or county) <u>Preston Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>Cornelia W. Plummer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.M. Morris</u>		ADDRESS <u>Stanton, Md.</u>	
DATE <u>12-14-55</u>							

11701

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE JR

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

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OCCUPATION

RELIGION

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